Interpersonal therapy in the general practice setting

KAY WILHELM AM, MB BS, MD, FRANZCP
ROBERT MAY MB BS

Interpersonal therapy is a useful tool for the treatment of patients with depression and other mental disorders. A shorter version is available for GPs, which offers a more tailored intervention and greater treatment options.

KEY POINTS

- Interpersonal therapy (IPT) has a strong evidence base for the treatment of depression.
- IPT offers a short-term, unique approach that differs from cognitive behavioural therapy (CBT).
- Interpersonal counselling (IPC) is a shorter, manual-based version of IPT that is readily adapted to the general practice setting.
- IPT and IPC formulate a patient's mental illness in the context of their social environment.
- IPC can be delivered by GPs and practice staff with an interest in psychological therapy with the aid of available manuals.
- IPT works well with the medical model and the use of antidepressant medications and lends itself more adaptively to some patient circumstances than CBT.
- IPT has been expanded to a wide range of mental disorders including anxiety, substance use and depression related to medical illness.
- An awareness of IPT and IPC allows a more tailored intervention and greater treatment options for GPs and patients.

MedicineToday 2017; 18(8): 41-49

Professor Wilhelm is a Consultant Psychiatrist, Consultation-Liaison Psychiatry Service, St Vincent's Hospital, Sydney; Professor and Head of Psychiatry, University of Notre Dame, Sydney; and Conjoint Professor, School of Psychiatry, UNSW Sydney. Dr May is a Psychiatry Registrar at St Vincent's Hospital, Sydney, NSW.

How did interpersonal therapy (IPT) originate?

Interpersonal therapy (IPT) was originally designed about 40 years ago in a research setting as a time-limited psychotherapy, and its effectiveness was compared with amitriptyline and 'treatment as usual' unstructured supportive psychotherapy. The two main investigators were Myrna Weissman, a social worker, and Gerald Klerman, a psychiatrist. They proposed a brief interpersonally-based treatment specific to each of four interpersonal domains – grief, interpersonal dispute, roles transition and interpersonal sensitivity – which, they hypothesised, precipitated and maintained depressive episodes (Table 1).[1] In the trial, the patients in the arms receiving IPT or antidepressant medication showed similar rates of improvement, but the combination of IPT and antidepressant medication had the greatest impact on acute symptom improvement and delaying further episodes. Klerman and Weissman went on to write the original textbook on IPT.[2]

A multicentre trial in the USA was conducted to test the efficacy of the antidepressant imipramine either with or without psychotherapy as maintenance treatment for depression.[3] The two short-term psychotherapies selected for the trial were cognitive behavioural therapy (CBT) and IPT. The patients in both psychotherapy arms showed similar rates of improvement, although manifested in different ways. The imipramine plus CBT group improved in dealing with depressogenic cognitions (thoughts) whereas the imipramine plus IPT group improved in interpersonal function. The interest in IPT as an active treatment in its own right was further informed by a growing interest in attachment behaviour (an important theory underpinning IPT).

What is IPT?

IPT is a time-limited manual-based psychotherapy. It is based on the premise that depression arises in an interpersonal context and that relationship problems (such as disrupted relationships or expectations of those relationships) play a part in precipitating and maintaining depressive episodes.

Therefore, the goals of IPT in relation to depression are to:

- relieve depressive symptoms
- educate patients about the link between their symptoms and events in their relationships
- improve skills in interpersonal areas that may be contributing to or exacerbating the depression.
- The components of IPT are (see Box 1 for more details):[4]
  - orientation to therapy
  - treatment in selected domain(s) – material can be shown to patients to help them select their preferred domains (Table 1)
  - termination of therapy
  - adding a maintenance phase, where required.

A recent review of studies involving IPT, CBT and antidepressant medication investigated how IPT performed in comparison with other standardised forms of treatment for adult outpatients with a primary diagnosis of major depressive disorder.[5] The authors undertook a systematic review of the eight identified randomised controlled trials comparing individual sole IPT with other standardised treatments for adults with major depression as the primary diagnosis.

The findings were consistent with those from previous studies, in that they reported

TABLE 1. IDENTIFYING THE FOUR DOMAINS FOR INTERPERSONAL THERAPY[1,2]

Domain*	Description	Examples
Grief reaction	Helping the patient mourn a loss, particularly a prolonged or unresolved response to a loss	Difficulty with grief after a death due to unresolved issues surrounding the loss
Interpersonal dispute	Teaching conflict management skills. This may require: • renegotiation • acceptance of an impasse • recognition that the relationship has broken down	Longstanding bitterness due to unresolved problems in a relationship; both parties 'stuck', not able to talk about problems
Role transition	Helping the patient learn how to navigate shifting roles; difficult role transitions are either unexpected, unwelcome, untimely or involve the need for considerable upheaval and change	Being retrenched, leaving home, developing a chronic or life-threatening illness, recovering after a long illness
Loneliness, isolation, interpersonal sensitivity	Improving the patient's social skills; vulnerable styles include anxious worrying, anxious irritability, shyness, perfectionism, high personal standards, interpersonally sensitive to rejection	Longstanding difficulties making friends, standing up for self, being taken seriously

* Domain or main stress area(s) associated with development and maintenance of a depressive episode.

1. COMPONENTS OF THE PHASES OF INTERPERSONAL THERAPY (IPT)

Orientation to therapy

- Take a full patient history, including symptom review and diagnostic evaluation
- Undertake an interpersonal inventory (closeness circle; Figure 1)
- Educate about depression and symptom management
- Assess the patient's need for medication
- Link symptoms to interpersonal context (interpersonal formulation)
- Work with the patient to identify the problem area(s)
- Explain the rationale for IPT
- Explain the patient's role in IPT, including discussion of the meaning of the 'sick role'
- Set a treatment contract

Treatment in the designated domain(s) selected

- Maintain the focus of treatment in the selected domain(s)
- Facilitate discussion of the problem, using techniques appropriate to the domain
- Attend to the patient's affective state, including any need for antidepressants
- Attend to the patient's interpersonal relationships Identify and tackle resistance and other obstacles as they arise
- Discuss termination of IPT from the outset (a loss and role transition in itself)

Termination

- Wind up and acknowledge the ending as a transition
- If interpersonal counselling (IPC) is performed by a GP, signal the return to 'business as usual'
- Anticipate future problems, consider maintenance and relapse prevention strategies
- Establish contingencies for future treatment (which may include formal booster sessions or another opportunity to use IPC or IPT in the future, if the need arises)

Maintenance

- Note the importance of recalling agreed goals and new roles
- Build in further formal booster sessions
- Maintain a social network
- Review relationships with healthcare providers
- Use cognitive behavioural therapy approaches to identify relapse cognitions and signs

similar efficacy for IPT and CBT, but (not surprisingly) CBT had more effect on cognitions and IPT on social function. The inclusion of antidepressant medications made a difference in some studies but not in others and varied by type; venlafaxine, imipramine and nortriptyline had more effect than selective serotonin reuptake inhibitors. Barth and colleagues noted that the outcomes suggested that several kinds of treatments are effective or efficacious for patients with depression and recommended that patients can be given a treatment that fits their personal preferences, and this in turn may may have a positive effect on the outcome.[5]

How does IPT compare with CBT?

Both IPT and CBT are intended to be time limited and instruction manuals are available to provide guidance on the content of sessions.

CBT identifies and addresses the cognitions and behaviours that precipitate and maintain depression. It implies that changes in how someone appraises situations can affect their mood and behaviour. The patient is encouraged to challenge these appraisals and replace them with more helpful ones. It works best with people who can identify their thought processes and use a questioning approach to changing their unhelpful thinking styles.

IPT focusses on stressors in the patient's interpersonal context and how they can make changes in their relationships with others, using the four domains (Table 1). The patient is encouraged to make changes in how they relate to their significant others and social network. This can be simply listed or undertaken by construction of a closeness circle, which graphically represents the patient's interpersonal network (Figures 1a and b). It can be useful to guide the direction of therapy and can serve as a reference for progress. It also recognises that when people are depressed and anxious, it is not always because they have dysfunctional thoughts (e.g. if dealing with a serious illness).

Early research into CBT aimed at showing when its results were equal to or better than antidepressant medication use. Indeed, a multicentre study used IPT as a different form of psychotherapy to CBT to ensure that any improvements in the CBT groups were due to the effect of psychotherapy in general.[3] From the outset, studies into the effectiveness of IPT have looked at the contributions made by IPT and antidepressant medications together and separately. IPT works well as a treatment on its own and works better in combination with antidepressant medications than CBT. GPs may be more comfortable prescribing an antidepressant and using the psychotherapy together. The importance of the 'sick role', as part of 'the medical model', is consistent with this finding (Box 2).[6]

How has IPT evolved?

IPT has become a well-accepted and empirically validated treatment for a variety of psychiatric disorders.[6] Evidence has supported its use for a variety of mood

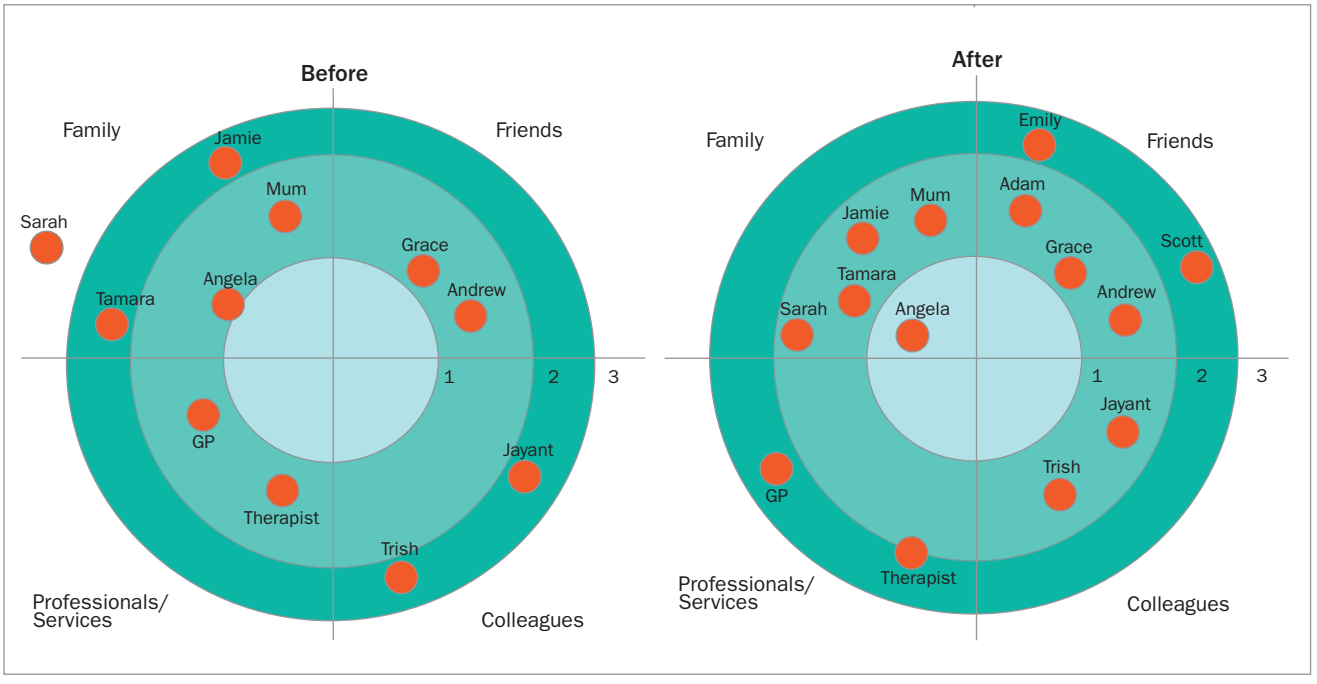

Figure 1a and b. Closeness circle: an interpersonal inventory. The closeness circle is a graphical representation of the patient's interpersonal network. Interpersonal inventory before (a, top) and after (b, bottom) interpersonal therapy. See Case scenario 1 in Box 4 for an example of how this tool can be implemented.

2. THE 'SICK ROLE' AS DEFINED IN THE MEDICAL MODEL[6]

- The idea behind the 'sick' role' is that the patient is someone who needs care and has an illness (a treatable condition), rather than being a 'defective person'.
- This also draws on the doctor–patient partnership as an opportunity to work collaboratively towards recovery.
- It empowers patients to decide and 'take charge' given the advice in their own biopsychosocial context.
- The idea of the 'sick role' as a temporary state to give the patient time and resources to work towards their recovery from their condition/illness is promoted by interpersonal therapy.

3. SOME FURTHER APPLICATIONS OF INTERPERSONAL THERAPY (IPT)[7]

The original IPT model for depression[6] has been adapted for the following uses.

Specific categories and contexts for depression

- Peripartum and postpartum depression
- Dysthymia
- Recurrent depression
- Depression in adolescence
- Depression in old age with mild cognitive impairment
- Depression in rural African settings
- Depression in patients with HIV
- Depression in patients with breast cancer
- Depression in patients with a history of low-level crime

Other disorders

- Bipolar disorder (interpersonal and social rhythm therapy)
- Anxiety disorders
- Post-traumatic stress disorder
- Substance abuse
- Disordered eating (i.e. anorexia, bulimia, prevention of obesity in adolescents)
- Personality disorders

disorders, anxiety disorders and eating disorders. IPT has the most evidence for its treatment of patients with depression, second only to CBT.[5] The use of IPT has continued to expand internationally with bodies such as the Interpersonal Psychotherapy Institute in the USA (https://iptinstitute.com) providing ongoing training and accreditation.

Although the focus of IPT was originally on depression, it has since been used for several other conditions.[7] Some of the adaptations are listed in Box 3.

CBT is the most commonly used psychotherapy for patients with depression, but not everyone can relate to its highly structured approach and it is not always applicable. There are also specific populations going through role transitions, such as those entering retirement or diagnosed with terminal illness and others engaged in interpersonal difficulties (either as disputes or attachment issues) where an IPT approach lends itself more intuitively to the therapeutic process (Table 2). These are also cases where a CBT approach may be useful for some specific issues before or after IPT. For example, it can be useful in identifying cognitions present as part of early relapse (relapse signature).

TABLE 2. AN EXAMPLE OF AN INTERPERSONAL APPROACH TO ROLE TRANSITION

The role I want to change to is to be a 'competent self-manager' of my life and my diabetes	
Advantages of changing to new role	**Disadvantages of changing to new role**
• I will feel stronger • I will have more control of my diabetes • I can tell my husband how I feel about all the late nights working • Being stronger with my family will help me lose weight • It may help me get a better sense of direction in life • I will be achieving something • I will set a good example for my kids	• My family may not listen or appreciate me changing • It means more is expected of me (I can not hide behind being helpless) • I will have to express my feelings • It may not work!
Advantages of NOT changing to new role	**Disadvantages of NOT changing to new role**
• I can stay with what I know • No one expects much of me	• My relationships may suffer • Family and friends will get fed up and see me as a burden • My health will probably suffer • I will feel bad about myself • This will reflect on my relationships • I will not be well enough to get a job • I will go on being depressed

How can IPT be used in general practice?

Having an idea of the process and domains of interpersonal problems helps GPs provide a framework for understanding problems and identifying patients who would most likely benefit from an interpersonal approach to psychotherapy (Table 3, Box 4 and Figure 2).[2,8-12] This can be implemented by the GP themselves in the form of interpersonal counselling (IPC)

TABLE 3. EXAMPLES OF INTERPERSONAL APPROACHES IN THE FOUR DOMAINS

Domain	Some examples of questions pertinent to the domains*
Grief reaction	• Can you tell me about … (the person who has died)? • What happened? How did you feel at the time? And now? • What are your own traditions of grieving? Have you used these? • How was your relationship with …? • How have you managed since the death? How has your life changed? • Have you had the support you wanted or expected? • Were there people you could count on when … died? • Later questions involve finding ways to remember the person and finding new roles – this may involve questions about role transition
Interpersonal dispute	• How do you express your anger to others? • How are you getting on with … (the person you have a dispute with)? • Are you having difficulty communicating with …? • Have you found yourself unhappy, disappointed and/or angry? • Are you happy with the way people treat you? • Can you tell me about the dispute or disagreement? • How well do you think people understand you? • In your current dispute, what are the issues? How does it make you feel? • Some disputes involve arguments and disagreement: you may need to find new ways of working things out (such as renegotiation) • Some disputes are quiet: you feel misunderstood, unheard, but do not talk about it, neither of you are communicating (at an impasse) • Some relationships feel as though they are ending, that they are beyond salvaging. Can you reconsider whether this is the situation? If this is the best course, it is still best to ensure that there is as little fallout as possible (dissolution) • Communication analysis example: Can you describe a dispute? What was said by you, by …? What happened? What did you want to happen?
Role transition	• Have you experienced changes in your relationships, life, work or health? • How would you describe your old role and your new role? • What are the positives and negatives in your old role? in your new one? • How were you before the change in role? How would you like to be? • What can you do to make your new life better? • Who is there to support you in making these changes?
Loneliness, isolation, interpersonal sensitivity	• Can you describe any close relationships you have had? • What problems do you have in your close relationships? • How frequently does this happen? • How do you approach people or get invited to social events or convey interest to people you are talking to? Does this turn our as you would like? If not, why not? • Can we practice this with some role playing?

or by referral to nursing or allied health professionals. Additionally, identification of a specific interpersonal focus of distress should trigger the GP to consider a provider trained in IPT as an alternative to CBT.

IPT works well with the medical model used in general practice and incorporates education about 'the sick role' and subsequent recovery. Unlike CBT, the IPT process is comfortable with concurrent prescription of medication, which may

4. CASE SCENARIOS: IMPLEMENTING INTERPERSONAL COUNSELLING

Case 1

Roy was a 37-year-old accountant who presented to his GP after the breakdown of his 12 year-long marriage with Angela, aged 34 years. He reported increasing arguments and frustration, with a 'tense and loveless' atmosphere at home. He worried how this might be affecting his children (Tamara, 14 years, and Jamie, 12 years). They had attended couples counselling with limited success, and Roy believed the situation had caused significant changes to his mood and had affected his performance at work.

He reported mood swings, problems controlling his anger and disturbed sleep. He asked the GP if he was depressed and for advice about whether he should separate from his wife for the sake of their children.

Given the interpersonal nature of Roy's problems, the GP considered interpersonal counselling and did the following.

- Reviewed whether Roy had clinical depression, performed a risk assessment and considered whether prescription of antidepressant medication would be useful. (The GP decided that Roy did not require antidepressant medication at this time).
- The GP became familiar with the process of interpersonal counselling.[9,11,12]
- In the initial IPC session, Roy chose 'interpersonal dispute' in the context of his marriage. He agreed to construct an interpersonal inventory, here shown by a closeness circle (see Figure 1a).
- In session 2, Roy discussed his current relationships. He divulged that the relationship first broke down four years ago, following his extramarital affair and subsequent withdrawal of intimacy by Angela. He identified that he and Angela were at an 'impasse', meaning that their efforts to resolve the dispute had stalled; however, neither party was actively attempting to end the relationship. Further exploration revealed that Roy felt guilty for his infidelity and the effects of this on Angela and the children.
- In session 3, the GP asked Roy to consider: What are the issues in the dispute? How likely is change to occur? How do Roy and Angela usually work on differences? Is there a pattern?[9]
- A communication analysis revealed that Roy expressed these feelings ineffectively leading to further misunderstandings and arguments. In session 3, problem-solving exercises were undertaken with to view to deciding if he wished to make changes or wanted to learn to live with an impasse in their marriage.
- In session 4, with the aid of role play with the therapist, Roy explored new ways of relating to Angela.
- In session 5, Roy reported that he had talked to Angela more openly and they had agreed to remain married until their youngest child was 16 years, and then reassess. They had decided to collaborate better, utilise clearer communication to minimise misunderstandings and draw on their wider social circle for support.
- In session 6, Roy's mood state had improved. The closeness circle was repeated and shown to have changed (see Figure 1b). The GP and Roy 'wrapped up' and reflected on what had been learnt and how to maintain improvement. The GP said Roy was welcome to come back and discuss the situation if he felt that he wanted to do any further work on his relationships in the future.

Case 2

Margaret was a 54-year-old married woman with a 10-year history of type 2 diabetes. She lived with her two children (Alex, 22 years, and Sara, 20 years) and husband Rob, 56 years, who was working long hours. One of her three close friends had recently moved interstate. She had also been caring for her elderly mother who had recently been placed in a nursing home. She acknowledged that she was 'too heavy', drank 'too much soft drink', engaged in 'comfort eating', smoked 10 cigarettes a day and 'should do more exercise'. She had experienced intermittent episodes of depression and occasional panic attacks.

She had been seeing her GP because of tiredness and poor glycaemic control. She stated that she had 'lost her purpose in life'.

The GP decided to consider the possibility of IPC and did the following.

- In session 1, the GP reviewed whether Margaret had clinical depression. IPC principles and treatment domains (Table 1) were discussed, including the 'sick role', the impact of depression on her daily function, risk issues and whether an antidepressant prescription was useful. Margaret was not keen to take antidepressant medications at that point.
- The GP and Margaret constructed an interpersonal formulation (see Figure 2). She was asked to think about her current roles (as wife, mother, worker and poor organiser of her current health) and to identify people in her interpersonal network, illustrated with the closeness circle. Margaret chose 'role transition' as a focus for change and they decided that the transition would be from a role of 'chronic, difficult patient' with little control of life and diabetes to a role of 'competent self-manager' of her diabetes.
- The GP and Margaret considered 'role transition' (see Table 2) from 'poor self-manager of diabetes to 'good self-manager' as a treatment focus.
- In session 2, the GP prescribed an antidepressant. They went through Margaret's closeness circle. She considered the pros and cons of staying 'as she is' and making changes. What would these changes look like? What would life look like without any changes? Who in her closeness circle would be available to support her with the changes?
- In two further sessions, they discussed the impact of antidepressant medication on her mood and any side effects. The GP supported her in discussing her new roles and how she related to her husband, children, mother and friends. This included Margaret deciding to involve two friends in an exercise program, discussing changing the diet with family and reviewing her relationship with her mother. (These sessions involved use of communication analysis and role play to encourage new relationship styles).
- A 'wrap up' session reviewed the changes and it was suggested that each three months, the GP and Margaret would review her progress and prevent relapse.

Note: Interpersonal counselling has a more structured approach than interpersonal therapy and is designed to be conducted with minimal training (by using a series of structured questions) and is suitable for use by GPs or practice nurses.

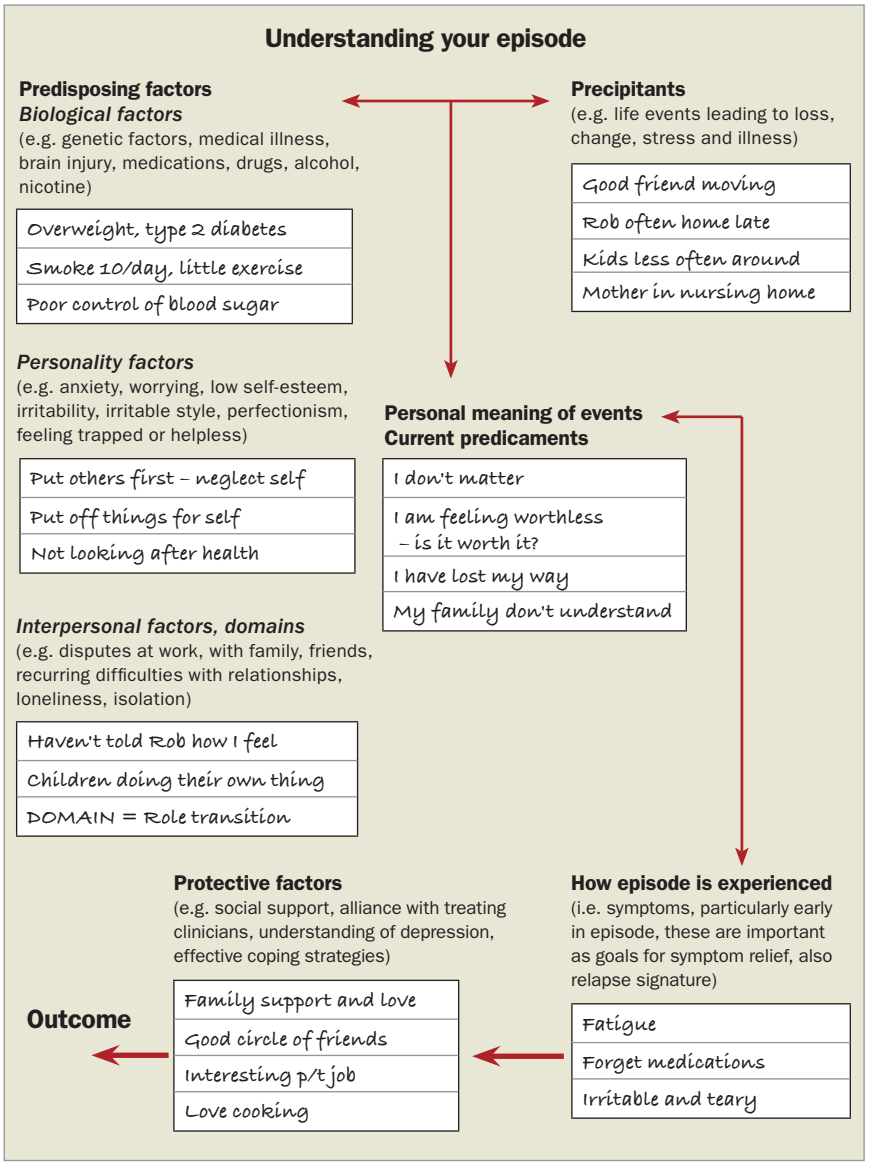

Figure 2. An interpersonal formulation.

be an important aspect of therapy. GPs can assist in commencing and titrating medications, medical interventions and lifestyle modifications alongside the therapy (Box 1).

What is interpersonal counselling?

IPC is a simplified and manual-based form of IPT.[13] It was developed for use in primary care for patients with depression and is for healthcare professionals whose backgrounds are outside mental health. It is highly structured and provides scripts to guide clinicians through the various stages over three to six sessions, again focusing on the same four domains as IPT (Table 3). It can be implemented by GPs with relative ease after training with the aid of supportive resources. It has been used by GPs in some settings and is a good way of learning about IPT. Resources for those interested in trying an interpersonal approach themselves or engaging practice

5. RESOURCES FOR THOSE INTERESTED IN TRYING AN INTERPERSONAL APPROACH

- **Black Dog Institute. Understanding your depressive episode. Sydney: Black Dog Institute; 2017.** Available online at: https://www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/22-understanding-your-depressive-episode.pdf?sfvrsn=2 (accessed July 2017).
- **Black Dog Institute. Exercise handout 2: weekly exercise plan. Sydney: Black Dog Institute; 2017.** Available online at: https://www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/2-exercisehandout1-weeklyexerciseplan.pdf?sfvrsn=2 (accessed July 2017).
- **Law, R. Interpersonal therapy: the model. Stafford, UK: NHS; 2010.** Available online at: http://www.sssft.nhs.uk/images/Psychological_Services/Interpersonal-Psychotherpay-The-Model.pdf (accessed July 2017).
- **Weissman MM, Markowitz JC, Klerman GL. Clinician's guide to interpersonal psychotherapy. New York: Oxford University Press; 2007.** There is also a brief guide available, printed in the same year from the same publisher.
- **World Health Organization (WHO) and Columbia University. Group interpersonal therapy (IPT) for depression. Geneva: WHO; 2016.** Available online at: http://apps.who.int/iris/bitstream/10665/250219/1/WHO-MSD-MER-16.4-eng.pdf (accessed July 2017).

  The IPT group manual is published by the World Health Organization (WHO). Although intended for groups, it gives an idea of questions that can be used for IPC for individuals as well.

  The WHO currently has a second version of an *Interpersonal Counselling for Primary Care* handbook written by Weissman and colleagues for individual therapy nearing publication. This will be available soon and will be noted on the same website.

6. HOW TO FIND AN INTERPERSONAL THERAPIST

Interpersonal psychiatrist

- Go to https://www.ranzcp.org
- Click 'Find a psychiatrist'
- Enter suburb or town and choose maximum distance away
- Choose primary problem and population treated
- Click 'Advanced search options'
- Choose 'Psychotherapy – Interpersonal' under the 'Treatment and services' option
- Click 'Search' for results

Interpersonal psychologist

- Go to https://www.psychology.org.au
- Click 'Find a Psychologist'
- Select the mental health issue
- Select the location and radius
- Click 'Find'
- Scroll down to panel on left called 'Therapeutic approaches'
- Click IPT for results

nurses are given in Box 5. Details on finding an interpersonal therapist are provided in Box 6.

Conclusion

There is now a range of effective, manual-based, short-term psychotherapies, which provide GPs and their patients with choice. The growing interest in IPT comes from evidence showing it is as effective as CBT. IPT can be used for a variety of psychiatric disorders. It incorporates the 'sick role' and works well for patients who are medically ill or require medication. GPs or their practice nurses could undertake IPC using a manual-based approach in its current form, whereas formal training is required for IPT. MT

Acknowledgements

The authors would like to thank Dr Christopher Wurm for comments on the final draft of this article.

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

COMPETING INTERESTS: None.

Interpersonal therapy
in the general practice setting

KAY WILHELM AM, MB BS, MD, FRANZCP; **ROBERT MAY** MB BS

References

1. Weissman MM, Prusoff BA, Dimascio A, Neu C, Goklaney M, Klerman GL. The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes. Am J Psychiatry 1979; 136: 555-558.
2. Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES. Interpersonal therapy of depression. 1st ed. New York: Basic Books; 1984.
3. Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental Health Treatment of Depression Collaborative Research Program. General effectiveness of treatments. Arch Gen Psychiatry 1989; 46: 971-982; discussion 983.
4. Robertson M, Rushton P, Wurm C. Interpersonal psychotherapy: an overview. Psychotherapy in Australia 2008; 14: 46-54. Available online at: http://www.psychotherapy.com.au/fileadmin/site_files/pdfs/Interpersonal Psychotherapy.pdf (accessed July 2017).
5. Barth J, Munder T, Gerger H, et al. Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. PLoS medicine 2013; 10: e1001454.
6. International Society of Interpersonal Psychotherapy Institute (isIPT). Overview of IPT. Brentwood, TN: isIPT: 2017. Available online at: https://www.interpersonalpsychotherapy.org/ipt-basics/overview-of-ipt (accessed July 2017).
7. Frank E, Ritchey F, Levenson JC. Is interpersonal psychotherapy infinitely adaptable? A compendium of the multiple modifications of IPT. Am J Psychotherapy 2014; 68: 385-416.
8. Stuart S, Robertson M. Interpersonal therapy: a clinician's guide. Boca Raton, FL: Taylor and Francis; 2012.
9. World Health Organization (WHO) and Columbia University. Group interpersonal therapy (IPT) for depression. Geneva: WHO; 2016. Available online at: http://apps.who.int/irisbitstream/10665/250219/1/WHO-MSD-MER-16.4-eng.pdf (accessed July 2017).
10. Mufson LH, Dorta KP, Moreau D, Weissman MM. Interpersonal psychotherapy for depressed adolescents, 2nd ed. New York: Guilford Press; 2004.
11. Weissman MM, Markowitz J, Klerman GL. Clinician's quick guide to interpersonal psychotherapy. New York: Oxford University Press; 2007.
12. Judd F, Weissman M, Davis J, Hodgins G, Piterman L. Interpersonal counselling in general practice. Aust Fam Physician 2004; 33: 332-337.
13. Weissman MM, Hankerson SH, Scorza P, et al. Interpersonal counselling for depression in primary care. Am J Psychotherapy 2014: 68; 356-383.